Name: DOB:/_	_/ Medicaid	d ID:	Record #:
Name: DOB:/_ Date of Initial Plan://			
'\$	PERSON-	CENTERED P	LAN
Person Responsible for Plan:	Service A	(State Fur uthorization By:	nding Only)
	Authoriza	ntion Date://	
Person's Preferred Name:		TYPE OF PLAN: (c	check all that apply)
Address:		☐ Initial Person-C	entered Plan
City/State/Zip:		Update/Revisio	n Date:/ / n including annual review
Home Phone: ()		of Medical Nec	essity <u>Date</u> ://
Work Phone: () ext.:			
Local Management Entity:			
Primary Care Physician:			
Medicaid County (If applicable):			
Medicare/Insurance:			
CONTACT PERSON(S)			
Emergency Contact or Next of Kin:			
Relationship to Person:			
Address:			
City/State/Zip:			
Home Phone: ()			
Work Phone: () ext			
Legally Responsible Person's Name:			
Telephone Number: ()			
If Appointed: (Attach copy of supporting documents)			
Date of Legal Document://			
Clinical Home Agency:			
First Responder Contact:			
Work Phone Number: () ext			
Cell Phone Number: ()			
Dames ()			

Name:	DOB://	Medicaid ID:	Record #:
Date of Initial Plan: / /			

PARTICIPANTS INVOLVED IN INITIAL PLAN DEVELOPMENT

Name:	Name:
Relation/Agency:	Relation/Agency:
Role: ☐ Facilitator of PCP meetings	Role: ☐ Facilitator of PCP meetings
☐ Participated in @ least 1 planning meeting	☐ Participated in @ least 1 planning meeting
☐ Provided written input	☐ Provided written input
☐ Telephone participation	☐ Telephone participation
☐ Invited, but no participation	☐ Invited, but no participation
Other:	Other:
Name:	Name:
Relation/Agency:	Relation/Agency:
Role: ☐ Facilitator of PCP meetings	Role: Facilitator of PCP meetings
☐ Participated in @ least 1 planning meeting	☐ Participated in @ least 1 planning meeting
☐ Provided written input	☐ Provided written input
☐ Telephone participation	☐ Telephone participation
☐ Invited, but no participation	☐ Invited, but no participation
Other:	Other:
Name:	Name:
Relation/Agency:	Relation/Agency:
Role: ☐ Facilitator of PCP meetings	Role: ☐ Facilitator of PCP meetings
☐ Participated in @ least 1 planning meeting	☐ Participated in @ least 1 planning meeting
☐ Provided written input	☐ Provided written input
☐ Telephone participation	☐ Telephone participation
☐ Invited, but no participation	☐ Invited, but no participation
Other:	Other:
Other individuals that I or my family would like to be part of this	s planning process now or in the future.

Name:	DOB: _	//		Medicaid ID:	Record #:
Date of Initial Plan:/					
	F	Person	nal In	terview	
Da	ate(s) o	f Intervi	view(s	s):/	
50	110(0) 0		1011(0	/)·/	
(This section must include what is important environment, culture, ethnicity and race as a ABOUT THIS PERSON. SIGN NAME (NO IN	ppropriate	e.) ADD/I AND DAT	REVIS	E INFORMATION XT TO THE CHAN	WHENEVER NEW THINGS ARE LEARNED
What has happened in my life this past year	<u>r</u> ? (Includ	le exciting	g, fun t	hings as well as ch	allenges and concerns):
Long Term Goals: (What are the things I wa	nt to acco	molish in	the ne	ext vear? What are	my hones/dreams for the future?)
Long Form Could. (What are the thinger was	11 10 4000	mphon m	1 1110 110	mi your. What are	my hopos/around for the fatare.)
Strengths: (What am I good at doing? What	do neonle	admire :	about	me? What are my	talents/gifts?)
Outenging. (What am I good at doing: What	do peopi	daniio	about	me: What are my	talents/gitts:/
Preferences: What is important TO me: (Wh	at are the	neonle/a	activitie	s/things/places tha	at matter to me in everyday life? What I don't
want in my life?)	at are tric	, рооріо, а	aotivitio	o, a in 190, places and	a matter to me in everyddy me. What i den t
, ,					
Needs: (What would I change about my life?	What is r	not workin	na in m	v life? What do I n	need in order to be an active part of my
community? What do I need to be healthy and	d safe?)			.,	
, ,	,				
Supports: What is important TO me? (What	do others	need to	know o	or do to support me	hest in relationships in things Llike to do in
work or school and ways to stay healthy and s	afe?)	TICEU IU	KI IOW (or an in anti-	, 2001 in rolationships, in things tine to do, in
	- /				

Name:	DOB://	Medicaid ID:	Record #:		
Family/Lagally D	aananaihla Dara	on/Informal Comparts Inter			
Family/Legally Responsible Person/Informal Supports Interview (This section must include what is important TO the person and what is important FOR the person from the interviewee's perspective. Also include issues related to the person's environment, culture, ethnicity and race as appropriate.) ADD/REVISE INFORMATION WHENEVER NEW THINGS ARE LEARNED ABOUT THIS PERSON. SIGN NAME (NO INITIALS) AND DATE (NEXT TO THE CHANGE), EACH TIME THIS SECTION IS ADDED TO OR REVISED.					
What has happened in this person's life thi	s past year? (Include	exciting, fun things as well as challeng	es and concerns):		
Long Term Goals: (What are the things the pthe future?)	person wants to accom	plish in the next year? What are this p	erson's hopes/dreams for		
Strengths: (What is this person good at doing	g? What do people ad	mire about this person? What are this	person's talents/gifts?)		
Preferences: What is important TO this person	on. (M/hat are the near	ale /activities /this was /ale acceptant and the standard	a this paragon in averyday		
life? What does the person not want in his/her		ole/activities/triings/places that matter to	o tilis person in everyday		
Needs: (What would this person change about order to be an active part of the community? \			t does this person need in		
Supports: What is important FOR this persor things he/she likes to do, in work or school and			n best in relationships, in		

Name:	DOB:/_	/	Medicaid ID:	Record #:
Date of Initial Plan:/				
Serv	vice/Supp	ort Pr	oviders Interview	
(This section must include what is important T o Also include issues related to the person's en WHENEVER NEW THINGS ARE LEARNE CHANGE), EA	nvironment, cu D ABOUT TH	ulture, et IS PERS	nnicity and race as appro	priate.) ADD/REVISE INFORMATION NITIALS) AND DATE (NEXT TO THE
What has happened in this person's life this	nast voar? (nclude e	voiting fun things as well	as challenges and concerns):
what has happened in this person's me this	past year : (I	iliciade e	xciting, full things as well	i as challenges and concerns).
Long Term Goals: (What are the things the pe	erson wants to	accomp	lish in the next year? WI	nat are this person's hopes/dreams for
the future?)				
Strengths: (What is this person good at doing'	? What do pe	ople adn	nire about this person? V	Vhat are this person's talents/gifts?)
Preferences: What is important TO this person		he peop	e/activities/things/places	that matter to this person in everyday
life? What does the person not want in this per	son's life?)			
Needs: (What would this person change about				's life? What does this person need in
order to be an active part of the community? W	hat does he/s	he need	to be healthy and safe?)	
Supports: What is important FOR this person?	(What do ot	hers nee	d to know or do to suppo	rt this person best in relationships, in
things he/she likes to do, in work or school and	ways to stay I	nealthy a	nd safe?)	

Name:	- / /	DOB:	/ / Me	dicaid ID:	R	ecord #:
Date of Initial Plan:	://					
	SU	JMMARY OF	ASSESSMEN'	TS/OBSERVAT	TONS	
ASSESSMENTS (Include medic	cal/dental if	ISSUE	ISSUES TO ADDRESS LAS			APPROXIMATE DUE DATE
applicable) Diagnostic Assessment &/or				/ /		/ /
Evaluation (90801 NC TOPPS (MH/S				/ /		1 1
				/ /		/ /
				/ /		1 1
ADDITIONAL AS		ISSUE	ES TO ADDRESS		XIMATE DUE	DATE COMPLETED
RECOMM	ENDED			/ /	DATE	1 1
				1 1		1 1
				/ /		1 1
	(DSM* (Code)		(Diagnosis)		(Diagnosis Date)
Axis I						/ /
Axis II Axis III						1 1
Axis IV						
Axis V						1 1
kis II: Major Mental kis II: Personality Co kis III: Any Non-Psyd kis IV: Social Function	Disorders: Developmenditions and Mental chiatric Medical Concorning and how symptomers.	mental Disorders ar I Retardation dition toms affect the pers	d Learning Disabilities			nt Scale, also a 100-point
Rec Services/Support	ommendations fo t/Treatment From		Frequency:	Duration:	Target Date	: State/Medicaid/ Health Choice
1.					/ /	
2.					/ /	
3.					/ /	
Symptoms/Obser 1. 2. 3. 4.	vations of this Pe	erson:				

Name:	DO	DB://	Medicaid ID:	Recor	d #:
		ACTION	PLAN		
Long Range Outcome: (Ensure that this is an outc	ome desired by th	ne individual, and not a	goal belonging to others	s.)
Where am I now in relat	ion to this outcome?				
SYMPTOM/OBSERVAT	ION #:				
	ken from Preferences & What's important TO &		rvention to Reach n from Supports	Who will Provide Support/Intervention/	Support/Service & frequency
	me")		ections)	Service?	a frequency
Target Date (Not to exceed 12 months.)	Reviewed Date	Status Code	Justification for	Continuation/Discontinuation	nuation of Goal
/ /	/ /	Code			
/ /	/ /				
/ /	/ /				
Status Codes:	R=Revised	O=Ongoing	A=Achieved	d D=Discontinu	ed
		o ongoing	7. 7.0		
SYMPTOM/OBSERVAT	ION #:				
Short Range Goal (Tal	ken from Preferences & What's important TO &		rvention to Reach n from Supports	Who will Provide Support/Intervention/	Support/Service & frequency
FOR	me")		ections)	Service?	a frequency
Target Date (Not to exceed 12 months.)	Reviewed Date	Status Code	Justification for	Continuation/Discontinuation	nuation of Goal
/ /	/ /	2340			
/ /	/ /				
1 1		+			

O=Ongoing

A=Achieved

R=Revised

Status Codes:

D=Discontinued

Name:	DO	B://	Medicaid ID:	Recor	rd #:
ACTION PLAN CONTINUATION					
Long Range Outcome: (Ensure that this is an outco	ome desired by t	he individual, and not a	a goal belonging to others	s.)
Where am I now in relat	ion to this outcome?				
SYMPTOM/OBSERVAT	ION #:	T		<u></u>	
				Support/Service & frequency	
			,		
Target Date (Not to	Reviewed Date	Status	Justification for	Continuation/Disconti	nuation of Goal
exceed 12 months.)	/ /	Code	oustilication for	Continuation/Discontin	indation of Goal
/ /					
/ /	/ /				
/ /	/ /				
Status Codes:	R=Revised	O=Ongoing	A=Achieve	d D=Discontinu	ied
SYMPTOM/OBSERVAT	ION #:	T		T	T
		Support/Intervention to Reach Goal (Taken from Supports Sections)		Who will Provide Support/Intervention/ Service?	Support/Service
	,		,		
- 15 : 0: :					
Target Date (Not to exceed 12 months.)	Reviewed Date	Status Code	Justification for	Continuation/Disconti	nuation of Goal
/ /	/ /				
/ /	/ /				

R=Revised

Status Codes:

O=Ongoing

A=Achieved

D=Discontinued

Name:	DOB://	/ Medicaid ID: _	Record #: _			
CRISIS PREVENTION/CRISIS RESPONSE (Use this form and/or attach your crisis plan.)						
Symptoms/behaviors that may trigger	the onset of a crisis ((include lessons lear	ned from previous crisis events):			
Crisis prevention and early intervention	n strategies (List eve	erything that can be o	done to help this person avoid a c	risis):		
steps. Include process for obtaining ba	Strategies for crisis response and stabilization (Focus first on natural and community supports. Begin with least restrictive steps. Include process for obtaining back-up in case of emergency and planning for use of respite, if an option. List everything you know that has worked to help this person to become stable):					
Specific recommendations if person are	Specific recommendations if person arrives at the Crisis and Assessment Service:					
All Current Medications (* Update and revise list of medications anytime there is a change)	Dose:	Frequency:	Reason for Change:	Date		
				/ / / / / /		
After the crisis, identify strategies for o	determining what wo	rked and what did no	ot work, and make changes to the	plan:		

Name:	DOB:// Me	dicaid ID:	Record #:
Date of Initial Plan://			
CDIOIC		DONCE (CA	
CRISIS	PREVENTION/CRISIS RES	PONSE (CC	DNTINUATION)
Contact List (Include names a	s applicable, relationship and direct pho	one numbers or	extension.)
First Responder:	Telephone #: ()	C	onsent/Release of Information: Yes No
Legally Responsible Person:(If applicable)	Telephone #: ()	C	onsent/Release of Information: Yes No
Natural/Community Supports:			
Name:	Telephone #: ()	C	onsent/Release of Information: Yes No
Name:	Telephone #: ()	C	onsent/Release of Information: Yes No
Professional Supports:			
Name:		C	onsent/Release of Information: Yes No
Primary Care Physician:Consent/Release of Information: _	Yes No	Te	elephone #: ()
Preferred Psychiatric Inpatient /Re	spite Provider:	To	elephone #: ()
Consent/Release of Information:	」Yes □ No		
Other Professional Supports:			
Name:			onsent/Release of Information: Yes No
Name:	_ Telephone #: ()	C	onsent/Release of Information: Yes No
Advanced Directives: (Advance D speak for yourself).	irectives allow you to plan ahead for ca	re in the event	that there are times that you are unable to
☐ Yes ☐ No I have a Living W	ill.		Yes 🗌 No I would like one.
Yes No I have a Health C	are Power of Attorney.		Yes No I would like one.
☐ Yes ☐ No I have an Advance	ed Instruction for Mental Health Treatn	nent.	Yes No I would like one.
Crisis Plan Distribution Lis	st (List contact information):		

Name: DOB:/_	/	Medicaid ID:	Record #:
Date of Initial Plan://			
Comments or Concerns on Plan by the person whose p	lan this is	and/or the legally re	sponsible person:
Steps to address concerns:			
•	Signat	ures	
REQUIRED for Medicaid funded se	micas Di	COMMENDED for St	ata fundad aaniaaa
My signature below confirms that medical necessity for	services	requested is present	, and constitutes the Service Order(s):
Signature:			Date://
(Name/Title Required. Must be licensed physician, licensed psychological	ologist, licen	sed physician's assistant	or licensed family nurse practitioner.)
Annual review of medical necessity and re-ordering	ng of serv	vices is due on or b	pefore://
Person Receiving Services:			
I confirm and agree with my involvement in the dev	velopment	of this person-centered	d plan. My signature means that I agree
with the services/supports to be provided.	•	•	
 I understand that I have the choice of service proviperson responsible for my plan. 	ders and r	nay change service pro	oviders at any time, by contacting the
Signature:			Date: / /
(Required when person is his/her own legally responsible person)			Date//
(q p p g, g, p p			
The following signatures confirm the involvement of			t of this person-centered plan. All
 signatures indicate agreement with the services/supple. For state-funded services, if the first signature box or 			he signature of the Person Responsible
for the Plan in this box constitutes the Service Order	. Complet	te the Annual Review	date if this is the Service Order.
Legally Responsible Person Signature:			Date://
(Required, if other than the individual)			
Person Responsible for the Plan Signature:(Required)			Date://
Annual Review of medical necessity and re-orderi	ng of Sta	te-funded services	is due on or before://
Other Team Member Signature:			Date://
Other Team Member Signature:			Date://

Name:	DC	B:/	Medicaid ID:	Recor	d #:
Date of Initial Plan:/	/				
	☐ Plan U	Indate/Revis	sion - Date:/	/	
			Necessity - Da		
(Continue to address	what is important TO and I				te to the person's
•			ty, and race as approp		·
			,	,	
Long Range Outcome:					
Where am I now in relati	ion to this outcome?				
SYMPTOM/OBSERVAT	ION #:				
	ken from Preferences &	Support/Inte	rvention to Reach	Who will Provide	Support/Service
Supports Sections ("	What's important TO &		n from Supports	Support/Intervention/	oupport oct vice
				Service?	
FOR	! me")	56	ections)	Service:	
Target Date (Not to	Reviewed Date	Status	luctification for	r Continuation/Disconti	austion of Goal
	Reviewed Date		Justilication for	Continuation/Discontin	iuation of Goal
exceed 12 months.)		Code			
/ /	/ /				
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/ /	/ /				
' '	, ,				
	<u> </u>				
Status Codes:	R=Revised	O=Ongoing	A=Achieve	d D=Discontinu	ed

Provide signatures on the next page

Plan Update/Revision - Date:// [continued] Annual Review of Medical Necessity – Date:// [continued] Signatures REQUIRED for Medicaid funded services. RECOMMENDED for State funded services. If this Update/Revision includes a NEW service(s) and/or is the annual review of medical necessity, my signature below confirms that medical necessity for the service(s) requested is present and constitutes the Service Order(s): Signature: Date:// (Name/Title Required. Must be licensed physician, licensed psychologist, licensed physician's assistant or licensed family nurse practitioner.)
REQUIRED for Medicaid funded services. RECOMMENDED for State funded services. If this Update/Revision includes a NEW service(s) and/or is the annual review of medical necessity, my signature below confirms that medical necessity for the service(s) requested is present and constitutes the Service Order(s): Signature: Date://
If this Update/Revision includes a NEW service(s) and/or is the annual review of medical necessity, my signature below confirms that medical necessity for the service(s) requested is present and constitutes the Service Order(s): Signature: Date://
confirms that medical necessity for the service(s) requested is present and constitutes the Service Order(s): Signature: Date://
Annual Review of medical necessity is due on or before://
Payan Passiving Comissos
Person Receiving Services:
 I confirm and agree with my involvement in the development of this update/revision to my person-centered plan. My signatur means that I agree with the services/supports to be provided. I understand that I have the choice of service providers and may change service providers at any time by contacting the person responsible for my plan.
Signature: Date://_
Signature: Date:// (Required when person is his/her own legally responsible person)
 The following signatures confirm the involvement of individuals in the development of this update/revision to the person-centered plan. All signatures indicate agreement with the services/supports to be provided. For State-Funded services, if the first signature box on this page is not completed AND this Update/Revision includes a NEW service(s) and/or is the annual review of medical necessity, the signature of the Person Responsible for the Plan in this box constitutes the Service Order. Complete the Annual Review date if this is the Service Order.
Legally Responsible Person Signature:
(Required, if other than the individual)
Person Responsible for the Plan Signature: Date:// (Required)
Annual Review of medical necessity and re-ordering of State-funded services is due on or before://
Other Team Member Signature: Date:/
Other Team Member Signature: Date://